

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**HOUSTON INDEPENDENT SCHOOL DISTRICT  
OFFICE OF SPECIAL EDUCATION SERVICES**

**ARD/IEP Notice of and Consent for Release and Receipt of Information to Access Medicaid Reimbursement**

Name:	_____	ID:	_____	DOB:	_____	Date Sent:	_____
Disability (ies):	_____	Grade:	_____	School:	_____	Field Office:	_____

Your child's Individualized Education Program (IEP) includes special education and related services provided by the Houston Independent School District (Houston ISD) special education staff. One or more of the school-based services included on your child's IEP may be eligible for Medicaid reimbursement to Houston ISD. Medicaid is a public insurer that the Houston ISD routinely accesses to assist the school district in meeting the costs of providing special education and related services.

Changes in federal regulations (34 CFR § 300.154(d)(2)(iv)(A)-(B)), require Houston ISD to (a) seek your one-time consent to exchange information with and to submit bills to Medicaid for reimbursement, and (b) inform you of why the consent is requested. The type of information that Houston ISD may disclose can include records or information about the health services and related services that are provided to your child. The purpose of the disclosure to state and/or federal Medicaid representatives is to seek reimbursement from Medicaid for the health and related services that your child receives at school.

Once the Houston ISD obtains this one-time consent, the district will not be required to obtain any further parental consent in the future before it accesses your or your child's public benefits or insurance regardless of whether there is any change in the type, amount, or cost of services to be billed to the public benefits or insurance program (e.g. Medicaid). However, the Houston ISD will annually thereafter provide you with written notification that it will access your or your child's public benefits or insurance.

It is important to understand that your child's Medicaid eligible health care services outside of the school setting will not be limited or decreased if you grant consent for Houston ISD to bill Medicaid for school related services. Medicaid has no lifetime maximum amount of services to children which are eligible for reimbursement. If the service your child receives is not eligible for reimbursement, Medicaid will not be billed.

Houston ISD ensures that your child will be provided the services specified in the IEP at no cost to you regardless of whether you consent to Houston ISD billing Medicaid for reimbursement; however, your consent will greatly assist the district in providing the highest quality of services to the children served by Houston ISD. The money collected from Medicaid is used to expand and enhance medical and related services for children. Your consent is voluntary and may be revoked at any time. Accordingly, the revocation is not retroactive and does not negate reimbursements that may have been received prior to your revocation.

Please check the appropriate box by each statement, sign your name, insert date, and return this form to:

\_\_\_\_\_ at \_\_\_\_\_ as soon as possible.  
School/Department Staff Person School/Department

☐ Yes ☐ No I have been fully informed and understand the release of information for the Medicaid SHARS reimbursement process.

☐ Yes ☐ No I understand that my consent for the release of information for the Medicaid SHARS reimbursement process is voluntary. If I decide to revoke my consent, the revocation does not negate an action that has occurred after the consent was given and before it was revoked.

☐ Yes ☐ No I have been informed in my native language or other mode of communication.

☐ Yes ☐ No I give consent for Houston ISD to release information regarding health and related services my child receives at school to state and/or federal Medicaid representatives for the purpose of allowing Houston ISD to seek reimbursement from Medicaid. This consent will be effective for the duration of my child's current IEP.

SIGNATURE OF PARENT, ADULT STUDENT, GUARDIAN, OR SURROGATE PARENT (circle one)

DATE \_\_\_\_\_

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SIGNATURE OF INTERPRETER, IF USED

DATE \_\_\_\_\_

\*If you have any questions or wish to revoke this consent, please contact:

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Case Manager or Special Education Senior Program Manager

at

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Phone Number